

# REFERRAL FORM: BEHAVIORAL HEALTH CARE COORDINATION FOR CHILDREN AND YOUTH

<b>DEMOGRAPHIC INFORMATION</b>	<b>Date of Referral:</b> <a href="#">Click here to enter a date.</a>
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<b>Youth Name:</b> <a href="#">Click here to enter text.</a> <b>Youth Phone:</b> <a href="#">Click here to enter text.</a> <b>Cell Phone:</b> <a href="#">Click here to enter text.</a> <b>Gender:</b> <input type="checkbox"/> M/ <input type="checkbox"/> F <b>DOB:</b> <a href="#">Click here to enter text.</a>	<b>Address:</b> <a href="#">Click here to enter text.</a> <b>City:</b> <a href="#">Click here to enter text.</a> <b>Zip Code:</b> <a href="#">Click here to enter text.</a> <b>State:</b> <a href="#">Click here to enter text.</a> <b>MA#:</b> <a href="#">Click here to enter text.</a> <b>SS#:</b> <a href="#">Click here to enter text.</a>
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<b>Parent/Legal Guardian(s) (if legal guardian, a court order must be attached):</b> <a href="#">Click here to enter text.</a>	
<b>Address (if different from child):</b> <a href="#">Click here to enter text.</a>	<b>Cell:</b> <a href="#">Click here to enter text.</a>
<b>Parent/Guardian Phone:</b> <a href="#">Click here to enter text.</a>	<b>Email:</b> <a href="#">Click here to enter text.</a>

<b>Ethnicity/Race</b>	
<input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Hispanic, Latino or Spanish origin <input type="checkbox"/> Not Available	
Primary Language: <a href="#">Click here to enter text.</a>	
Are interpreter services required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Deaf or hearing impaired	
<input type="checkbox"/> Blind	
Special Accommodations: <a href="#">Click here to enter text.</a>	

<b>School/Education:</b>	
Current School: <a href="#">Click here to enter text.</a> Current Grade <a href="#">Click here to enter text.</a>	Not in School <a href="#">Click here to enter text.</a>
Special Education Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	IEP <input type="checkbox"/> 504 Plan <input type="checkbox"/>
Guidance Counselor: <a href="#">Click here to enter text.</a> Phone: <a href="#">Click here to enter text.</a>	

<b>Living Situation:</b> Does this youth currently live or have a plan to live in a group home or any other congregate group setting other than a family or foster home? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Behavioral Health Diagnosis** Diagnosed By: [Click here to enter text.](#)

Diagnosis	ICD Code
a. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
b. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
c.	

**Medical Diagnoses Impacting Behavioral Health Diagnosis:**  None

Diagnosis	ICD code
a. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
b. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
c.	

**Psychosocial/ Environmental Elements Impacting Diagnosis:**  None

Diagnosis	ICD Code
a. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
b. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
c.	

**Current Medication:**  None

Name	Dosage
a. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
b. <a href="#">Click here to enter text.</a>	<a href="#">Click here to enter text.</a>
c.	

**Primary Physician:** [Click here to enter text.](#)

**Phone Number:** [Click here to enter text.](#)

**Reason for Referral: (Please provide a brief explanation of the level the child/youth is being referred)**

[Click here to enter text.](#)

**Release of Information: (please review and have the parent/guardian sign the release)**

I understand that I am applying for Care Coordination in [Choose an item..](#) This service has been explained to me and I understand that if approved I will participate in development of a Plan of Care with a team of people working with my family. I authorize the release of information to the Care Coordination Organization in [Choose an item.](#) so they can conduct a full screening and initiate an eligibility determination by the Administrative Service Organization (ASO) to determine my eligibility for Care Coordination services. I understand that I may revoke my permission at any time by written or verbal request.

Signature of parent or legal guardian:	Date:
Witness Signature:	Date:

**Name of Person Making Referral:** [Click here to enter text.](#)

**Agency:** [Click here to enter text.](#) **Phone:** [Click here to enter text.](#)

**FAX:** [Click here to enter text.](#) **E-Mail** [Click here to enter text.](#)

**Please indicate the level of care that you intend to refer the youth** **Level I- GENERAL (must meet at least 2)**

- A.  participant is not linked to behavioral health services, health coverage or medical services;
- B.  participant lacks basic supports for education, income, shelter and food;
- C.  participant is transitioning from one level of intensity to another level of intensity of services;
- D.  participant needs care coordination services to obtain and maintain community-based treatment and services;

 **Level II- MODERATE (must meet at least 3)**

- A.  participant is not linked to behavioral health services, health insurance or medical services;
- B.  participant lacks basic supports for education, income, food or transportation;
- C.  participant is homeless or at risk of homelessness;
- D.  participant is transitioning from one level of intensity to another level of intensity of services including transitioning out of the following services:
- (1)  inpatient psychiatric or substance use services
- (2)  RTC; OR
- (3)  1915(i) services under COMAR 10.09.89
- E. Due to multiple behavioral health stressors within the past 12 month, the participant has a history of:
- (1)  of psychiatric hospitalizations, or
- (2)  repeated visits or admissions to:
- (a)  Emergency room psychiatric units;
- (b)  crisis beds; or
- (c)  inpatient psychiatric units ;
- F. Participant needs care coordination services to obtain and maintain community- based treatment and services;

 **Level III- INTENSIVE - must meet at least 1 of the below criteria and submit CON documents outlined in I-IX below.**

- A. Participant shall meet the following criteria to be eligible based on their impaired functioning and service intensity level:
- (1)  Transitioning from a residential treatment center to the community; or
- (2)  Be living in the community and;
- (a)  Be 6 through 21 years old and have:
- (i)  any combination of 2 or more inpatient psychiatric hospitalizations or emergency room visits in past 12 mo.; or
- (ii)  have been in RTC within the past 90 calendar days
- (3)  Be living in the community and;
- (a) Be 0 through 6 and:
- (i)  be referred directly from an inpatient hospital unit; or
- (ii)  if living in the community, have one or more psychiatric hospitalizations or emergency room visits in the last 12 mo.

**Level III referrals require submission of a psychosocial evaluation dated within 30 days prior to submission of application. This evaluation must address the following:**

- I. Identifying information.
- II. Reason for referral.
- III. Reports reviewed to complete this referral.
- IV. **Risk of Harm**- Indicate child's potential to be harmed by others or cause significant harm to self or others.
- V. **Functional Status**- Indicate the degree to which the child or adolescent is able to fulfill responsibilities and interact with others. Include educational.
- VI. **Co-Occurrence of Conditions**-Developmental, medical, substance use, and psychiatric. Include DSM 5 diagnosis and medications, both current and past.
- VII. **Recovery Environment**- Indicate environmental factors that have the potential to impact a youth's efforts to achieve or maintain recovery. Include description of family constellation and commitment.
- VIII. **Resiliency and/or Response to Services**-Indicate the child or adolescents ability to self-correct when there are disruptions in the environment. Include any major life changes and how the child or adolescent responded.
- IX. **Involvement in Services**- Indicate the quantity and quality of the child/youth and primary care taker's involvement in services. Include involvement with other agencies; list all inpatient and outpatient treatments, and out of home placements (i.e. group homes, shelters, foster care or RTCs)

## Care Coordination Organization Contacts

<b>Jurisdiction</b>	<b>CCO Name</b>	<b>CCO Phone #</b>	<b>CCO Fax#</b>
Allegany	Potomac Case Management	301791-3087	301-393-0730
Anne Arundel	Center for Children	301-609-9887	301-609-7284
Baltimore City	Empowering Minds Resource Center	410-625-5088	410-625-4890
	Hope Health Systems	410-265-8737	410-265-1258
	Optimum Maryland	410-233-6200	410-233-6201
	Volunteers of America	240-579-6698	301-560-8505
	Wraparound Maryland	443-449-7713	443-451-8268
Baltimore County	Hope Health Systems	410-265-8737	410-265-1258
Calvert	Center for Children	410-535-3047	410-535-3890
Caroline	Wraparound Maryland	410-690-4805	410-690-4806
Carroll	Potomac Case Management	443-244-4113	443-293-7086
Cecil	Advantage Psychiatric Services, LLC	410-686-3629	410-392-3417
Charles	Center for Children	301-609-9887	301-609-7284
Dorchester	Wraparound Maryland	410-690-4805	410-690-4806
Frederick	Potomac Case Management	443-244-4113	240-578-4885
Garrett	Burlington United Methodist Family Services	301-334-1285	301-334-0668
Harford	Empowering Minds Resource Center	443-484-2306	443-484-2970
Howard	Center for Children	240-291-6984	301-609-7284
Kent	Wraparound Maryland	410-690-4805	410-690-4806
Montgomery	Volunteers of America	240-696-1565	301-306-5105
Prince George's	Center for Children	240-682-2253	301-609-7284
Queen Anne's	Wraparound Maryland	410-690-4805	410-690-4806
St. Mary's	Center for Children	301-475-8860	301-475-3843
Somerset	Wraparound Maryland	410-219-5070	410-219-5072
Talbot	Wraparound Maryland	410-690-4805	410-690-4806
Washington	Potomac Case Management	301-791-3087	301-393-0730
Wicomico	Wraparound Maryland	410-219-5070	410-219-5072
Worcester	Wraparound Maryland	410-219-5070	410-219-5072

Should you require additional assistance or need information or clarification about the services, you may contact the Local Behavioral Health Authority/Core Service Agency. A full directory of CSAs/LBHAs is available at <https://www.marylandbehavioralhealth.org/>.

<b>ALLEGANY COUNTY Allegany Co. Local Behavioral Health Authority</b> P.O. Box 1745, Cumberland, Maryland 21502-1745 Phone: 301-759-5070 Fax: <b>301-777-5621</b>	<b>ANNE ARUNDEL COUNTY Anne Arundel County Mental Health Agency</b> PO Box 6675, MS 3230, 1 Harry S. Truman Parkway, 101 Annapolis, Maryland 21401 Phone: 410-222-7858 Fax: <b>410-222-7881</b>
<b>BALTIMORE CITY Behavioral Health System Baltimore</b> 100 S. Charles Street, Tower II; 8th Floor; Baltimore, Maryland 21201-3718 Phone: 410-637-1900 Fax: <b>410-637-1911</b>	<b>BALTIMORE COUNTY Baltimore County Department of Health, Bureau of Behavioral Health</b> 6401 York Road, Third Floor Baltimore, Maryland 21212 Phone: 410-887-3828 Fax: <b>410-887-8537</b>
<b>CALVERT COUNTY Calvert County Local Behavioral Health Authority</b> 975 Solomons Island Road, Prince Frederick, Maryland 20678 Phone: 443-295-8584 #101 Fax: <b>443-968-8979</b>	<b>CARROLL COUNTY Carroll County Health Department, Bureau of Prevention, Wellness, and Recovery</b> 290 South Center Street, Westminster, Maryland 21158-0460 Phone: 410-876-4449 Fax: <b>410-876-4832</b>
<b>CECIL COUNTY Cecil County Core Service Agency</b> 401 Bow Street, Elkton, Maryland 21921 Phone: 410-996-5112 Fax: <b>410-996-5134</b>	<b>CHARLES COUNTY Department of Health Core Service Agency</b> P.O. Box 1050, 4545 Crain Hwy. White Plains, Maryland 20695 Phone: 301-609-5757 Fax: <b>301-609-5749</b>
<b>FREDERICK COUNTY Frederick County Health Department Behavioral Health Services</b> , 350 Montevue Lane, Frederick, Maryland 21702 Phone: 301-600-1755 Fax: <b>301-600-3214</b>	<b>GARRETT COUNTY Garrett County Behavioral Health Authority</b> 1025 Memorial Drive, Oakland, Maryland 21550-1943 Phone: 301-334-7440 Fax: <b>301-334-7441</b>
<b>HARFORD COUNTY Office on Mental Health of Harford County</b> 125 N Main Street, Bel Air, Maryland 21014 Phone: 410-803-8726 Fax: <b>410-803-8732</b>	<b>HOWARD COUNTY Howard County Health Department, Local Bureau of Behavioral Health</b> 8930 Stanford Boulevard, Ascend One Building, Columbia, Maryland 21045 Phone: 410-313-6202 Fax: <b>410-313-7374</b>
<b>MID-SHORE COUNTIES</b> (Includes <b>Caroline, Dorchester, Kent, Queen Anne and Talbot Counties</b> ) <b>Mid-Shore Mental Health Systems, Inc.</b> 28578 Mary's Court, Suite 1, Easton, Maryland 21601 Phone: 410-770-4801 Fax: <b>410-770-4809</b>	<b>MONTGOMERY COUNTY Department of Health &amp; Human Services, Montgomery County Government</b> 401 Hungerford Drive, 1st Floor, Rockville, Maryland 20850 Phone: 240-777-1400 Fax: <b>240-777-1145</b>
<b>PRINCE GEORGE'S COUNTY Prince George's County Health Department Behavioral Health Services Prince George's County Local Behavioral Health Authority</b> 9314 Piscataway Road, Suite 150 Clinton, Maryland 20735 Phone: 301-856-9500 Fax: <b>301-856-9558</b>	<b>SOMERSET COUNTY Somerset County Local Behavioral Health Authority, Somerset County Health Department</b> , 8928 Sign Post Road, Westover, MD 21871, Phone: 443-523-1790 Fax: <b>410-651-3189</b>
<b>ST. MARY'S COUNTY St. Mary's County Health Department</b> 21580 Peabody Street, Leonardtown, MD 20650 Phone: 301-475-4330 Fax: <b>301-363-0312</b>	<b>WASHINGTON COUNTY Washington County Mental Health Authority</b> 339 E. Antietam Street, Suite #5, Hagerstown, Maryland 21740 Phone: 301-739-2490 Fax: <b>301-739-2250</b>
<b>WICOMICO COUNTY Wicomico Behavioral Health Authority</b> 108 East Main Street, Salisbury, Maryland 21801, Phone: 410-543-6981 Fax: <b>410-219-2876</b>	<b>WORCESTER COUNTY Worcester County Local Behavioral Health Authority</b> P.O. Box 249, Snow Hill, Maryland 21863 Phone: 410-632-3366 Fax: <b>410-632-0065</b>